

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009307

STATE FILE NUMBER

MAR 19 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

1151

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Missouri		c. CITY OR TOWN Aurora	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kelly N.H.		d. STREET ADDRESS (If outside, give location) -	
3. NAME OF DECEASED (Type or print) First Middle Last Lydia Lila-Bunch Emilie Bunch		4. DATE OF DEATH Month Day Year March 2 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1866
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years) low birthdays 92
11a. BIRTHPLACE (City and state or country) Rockford, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel Brown		13b. MOTHER'S MAIDEN NAME Sally Johnson	
14. NAME OF HUSBAND OR WIFE William Bunch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT W. J. Bunch	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - DUE TO (c) Senile psychosis		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3118			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1950 to 1958 and last saw her alive on 2 mos ago Death occurred at 4:45 PM on 3/15/59 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) H. K. Miller, M.D.		22b. ADDRESS K.C. Mo.	
22c. DATE SIGNED 3/13/59		23a. BURIAL, CREMATION, REMOVAL (Specify) removal	
23b. DATE 3-5-59		23c. NAME OF CEMETERY OR CREMATORY Rose Hill	
23d. LOCATION (City, town, or county) Cottleville, Mo.		23e. (State) Billines	
24. FUNERAL DIRECTOR Sidmon Mortuary K.C. Mo.		25. DATE RECD. BY LOCAL REG. 3-3-59	
26. REGISTRAR'S SIGNATURE Neva Marshall			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~John~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *John F. Wood*

Licensed Embalmer No. *4727*
P. O. Address *Fanshawe*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.